Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING APPLICATION FOR CONSCIOUS SEDATION PERMIT

Enclosed is an application for a permit to administer conscious sedation in the state of Iowa. When completing this application, please be advised of the following.

- Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or conscious sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board.
- **Conscious sedation** is defined in Board rules as "a depressed level of consciousness produced by the administration of pharmacologic substances, that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command." A conscious sedation permit is required to administer conscious sedation in Iowa. [650 IAC 29.1(153)]
- **Deep sedation/general anesthesia** is defined in Board rules as "a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command." A deep sedation/general anesthesia permit is required to administer deep sedation/general anesthesia in Iowa. A deep sedation permit also allows the permit holder to administer conscious sedation.
  [650 IAC 29.1(153)]
- Licensees are encouraged to seek pre-approval of any formal training in conscious sedation prior to completing the course and applying for a permit. To apply for pre-approval, submit a copy of the course syllabus and related materials to the Board office.
- Each facility in which an applicant plans to provide conscious sedation is subject to an on-site evaluation prior to issuance of a permit. The actual costs associated with the on-site evaluation of the facility are the responsibility of the applicant. The cost to the licensee shall not exceed $500 per facility.
- Following review of a completed application and all required credentials by the Anesthesia Credentials Committee, a provisional permit may be issued pending final Board approval. A provisional permit may only be granted if the applicant will be practicing at a facility that has been inspected and approved by the Board.
- Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.
- Part three of the ADA guidelines (2003) for teaching the comprehensive control of anxiety and pain in dentistry states that, "Additional supervised clinical experience is necessary to prepare participants to manage children and medically compromised adults." Applicants should be prepared to document this additional clinical experience if your plans include the use of conscious sedation in children and medically compromised adults.
- Once issued, a permit must be renewed biennially at the time of license renewal. Permit holders are required to maintain current ACLS certification and document six hours of continuing education in the area of sedation for each renewal.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action.**
- All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650—Chapter 6.
- The application fee is non-refundable.

To assist you in completing the application, please utilize the following checklist and be sure that you have responded to each item.

☐ Type or legibly print the application.

☐ Complete each question on the application. If not applicable, answer N/A.

☐ Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your license or other documents.

☐ In section 3, basis for application, you must have completed parts one and three of the 2003 ADA guidelines AND one of the following: formal training in airway management; conscious sedation experience at the graduate level, approved by the board; or a formal training program approved by the Board.

☐ Include evidence of possessing a valid, current certificate in Advanced Cardiac Life Support (ACLS) by copying the front and back of your card.

☐ Complete and mail the appropriate form to your program director to verify your conscious sedation training.
- Applicants who received their training in a postgraduate residency program must have their postgraduate program director complete Form A.
- Applicants who received their training in a formal continuing education program must have the program director complete Form B.
- Applicants who completed a postgraduate residency program must attach a copy of your certificate of completion of the postgraduate program.

☐ Copy and complete page 3 of the application for each facility in which you plan to provide conscious sedation. Each facility is subject to inspection.

☐ Prior to completing the questions in section 9, read the following definitions.

"Ability to practice dentistry with reasonable skill and safety" means ALL of the following:
1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:
1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

☐ For each "Yes" answer in section 9, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).

☐ If you have a license, permit, or registration to perform conscious sedation in any other state, request verification of your permit from each state. Please note that some states may require a processing fee.

☐ The application must be notarized.

☐ Enclose the non-refundable application fee of $500, made payable to Iowa Dental Board.

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

APPLICATION FOR CONSCIOUS SEDATION PERMIT

SECTION 1 – APPLICANT INFORMATION				
Instructions – Please read the accompanying instructions prior to completing this form. Answer each question. If not applicable, mark "N/A."				
Full Legal Name: (Last, First, Middle, Suffix)				
Other Names Used: (e.g. Maiden)	**Home E-mail:**		**Work E-mail:**	
Home Address:	**City:**	**State:**	**Zip:**	**Home Phone:**
License Number:	**Issue Date:**	**Expiration Date:**	**Type of Practice:**	

SECTION 2 – LOCATION(S) IN IOWA WHERE CONSCIOUS SEDATION SERVICES ARE PROVIDED				
Principal Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**

SECTION 3 – BASIS FOR APPLICATION		
Check each box to indicate the type of training you have completed.	**Check if completed.**	**DATE(S):**
American Dental Association Council on Dental Education 2003 Guidelines Part 1	☐ Completed	
American Dental Association Council on Dental Education 2003 Guidelines Part 3	☐ Completed	
You must have training in ADA Parts 1 and 3 AND one of the following: **Formal training in airway management; OR**	☐ Completed	
Conscious sedation experience at graduate level, approved by the Board; OR	☐ Completed	
Formal training program approved by board.	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION	
Name of Course:	**Location:**
Date of Course:	**Date Certification Expires:**

Office Use				
	Lic. #	Brd Approved:	Inspection	Fee
	Permit #	Sent to ACC:	Temp #	ACLS
	Issue Date:		T. Issue Date:	Form A/B

Name of Applicant _____

SECTION 5 – CONSCIOUS SEDATION TRAINING INFORMATION

Type of Program:

☐ Postgraduate Residency Program ☐ Continuing Education Program ☐ Other Board-approved Program, specify:

Name of Training Program:	**Address:**	**City:**	**State:**

Type of Experience:

Length of Training:	**Date(s) Completed:**
Number of Patient Contact Hours:	**Total Number of Supervised Sedation Cases:**

☐ **YES** ☐ **NO** **1. Did you satisfactorily complete the above training program?**

☐ **YES** ☐ **NO** **2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?**

☐ **YES** ☐ **NO** **3. Does the program comply with parts one and three of the 2003 American Dental Association guidelines for teaching the comprehensive control of anxiety and pain in dentistry?**

As part of the curriculum, are the following concepts and procedures taught:

☐ **YES** ☐ **NO** **4. Physical evaluation;**
☐ **YES** ☐ **NO** **5. IV sedation;**
☐ **YES** ☐ **NO** **6. Airway management;**
☐ **YES** ☐ **NO** **7. Monitoring; and**
☐ **YES** ☐ **NO** **8. Basic life support and emergency management.**

☐ **YES** ☐ **NO** **9. Does the program include clinical experience in managing compromised airways?**

☐ **YES** ☐ **NO** **10. Does the program provide training or experience in managing conscious sedation in pediatric patients?**

☐ **YES** ☐ **NO** **11. Does the program provide training or experience in managing conscious sedation in medically compromised patients?**

Please attach the appropriate form to verify your conscious sedation training. Applicants who received their training in a postgraduate residency program must have their postgraduate program director complete Form A. In addition, attach a copy of your certificate of completion of the postgraduate program. Applicants who received their training in a formal continuing education program must have the program director complete Form B.

SECTION 6 – CONSCIOUS SEDATION EXPERIENCE

☐ **YES** ☐ **NO** **A. Do you have a license, permit, or registration to perform conscious sedation in any other state?**

If yes, specify state(s) and permit number(s):_____

☐ **YES** ☐ **NO** **B. Do you consider yourself engaged in the use of conscious sedation in your professional practice?**

☐ **YES** ☐ **NO** **C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, conscious sedation or deep sedation/general anesthesia?**

☐ **YES** ☐ **NO** **D. Do you plan to use conscious sedation in pediatric patients?**

☐ **YES** ☐ **NO** **E. Do you plan to use conscious sedation in medically compromised patients?**

☐ **YES** ☐ **NO** **F. Do you plan to engage in enteral conscious sedation?**

☐ **YES** ☐ **NO** **G. Do you plan to engage in parenteral conscious sedation?**

What major drugs and anesthetic techniques do you utilize or plan to utilize in your use of conscious sedation? Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.

Name of Applicant ____ Facility Address__________________________________

SECTION 7 – AUXILIARY PERSONNEL

A dentist administering conscious sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**

SECTION 8 – FACILITIES & EQUIPMENT

Each facility in which you perform conscious sedation must be properly equipped. Copy this page and complete for each facility. You may apply for a waiver of any of these provisions. The Board may grant the waiver if it determines there is a reasonable basis for the waiver.

YES	NO	Is your dental office properly maintained and equipped with the following:
☐	☐	**1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?**
☐	☐	**2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?**
☐	☐	**3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?**
☐	☐	**4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?**
☐	☐	**5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?**
☐	☐	**6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)**
☐	☐	**7. Is the patient able to be observed by a member of the staff at all times during the recovery period?**
☐	☐	**8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?**
☐	☐	**9. EKG monitor?**
☐	☐	**10. Laryngoscope and blades?**
☐	☐	**11. Endotracheal tubes?**
☐	☐	**12. Magill forceps?**
☐	☐	**13. Oral airways?**
☐	☐	**14. Stethoscope?**
☐	☐	**15. A blood pressure monitoring device?**
☐	☐	**16. A pulse oximeter?**
☐	☐	**17. Emergency drugs that are not expired?**
☐	☐	**18. A defibrillator (an automated defibrillator is recommended)?**
☐	☐	**19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?**
________		**20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.**

SECTION 9 – If you answer Yes to any of the questions below, attach a full explanation. Read the instructions for important definitions.

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	☐	☐
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐	☐
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	☐	☐
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐	☐
5. Have you ever been requested to repeat a portion of any professional training program/school?	☐	☐
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	☐	☐
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	☐	☐
7a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?	☐	☐
8. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?	☐	☐
9. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license or permit you held?	☐	☐
10. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?	☐	☐
11. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate or has your controlled substance registration ever been placed on probation, suspended, voluntarily surrendered or revoked?	☐	☐

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE:	**COUNTY:**

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide conscious sedation. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I understand that I have no legal authority to administer conscious sedation until a permit has been granted. I understand that my facility is subject to an on-site evaluation prior to the issuance of a permit and by submitting an application for a conscious sedation permit, I hereby consent to such an evaluation. In addition, I understand that I may be subject to a professional evaluation as part of the application process. The professional evaluation shall be conducted by the Anesthesia Credentials Committee and include, at a minimum, evaluation of my knowledge of case management and airway management.

I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under conscious sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and administering basic life support. I understand that a dentist performing a procedure for which conscious sedation is being employed shall not administer the pharmacologic agents and monitor the patient without the presence and assistance of at least one qualified auxiliary personnel.

I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of conscious sedation. I also understand that if conscious sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

I hereby authorize the release of any and all information and records the Board shall deem pertinent to the evaluation of this application, and shall supply to the Board such records and information as requested for evaluation of my qualifications for a permit to administer conscious sedation in the state of Iowa.

I understand that based on evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.

I further state that I have read the rules related to the use of conscious sedation, deep sedation/general anesthesia and nitrous oxide inhalation analgesia, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and conscious sedation in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ►	**SIGNATURE OF APPLICANT**	
NOTARY SEAL	**SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF , YEAR**	
	NOTARY PUBLIC SIGNATURE	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	**MY COMMISSION EXPIRES:**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

PLEASE TYPE OR PRINT LEGIBLY IN INK.

FORM A: VERIFICATION OF CONSCIOUS SEDATION TRAINING IN A POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 – APPLICANT INFORMATION

Instructions – Use this form if you obtained your training in conscious sedation from an approved postgraduate residency program. Complete Section 1 and mail this form to the Postgraduate Program Director for verification of your having successfully completed this training.

NAME (First, Middle, Last, Suffix, Former/Maiden):			
MAILING ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**PHONE:**

To obtain a permit to administer conscious sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:	**DATE:**

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

THIS POSTGRADUATE PROGRAM IS APPROVED OR ACCREDITED TO TEACH POSTGRADUATE DENTAL OR MEDICAL EDUCATION BY ONE OF THE FOLLOWING:

- ☐ **American Dental Association;**
- ☐ **Accreditation Council for Graduate Medical Education of the American Medical Association (AMA); or**
- ☐ **Education Committee of the American Osteopathic Association (AOA).**

NAME AND LOCATION OF POSTGRADUATE PROGRAM:			**PHONE:**
DATES APPLICANT PARTICIPATED IN PROGRAM ►	**FROM (MO/YR):**	**TO (MO/YR):**	**DATE PROGRAM COMPLETED:**

☐ **YES** ☐ **NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM?**

☐ **YES** ☐ **NO 2. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?**

☐ **YES** ☐ **NO 3. DOES THE PROGRAM COVER PARTS 1 AND 3 OF THE 2003 AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF ANXIETY AND PAIN?**

☐ **YES** ☐ **NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE IN MANAGING COMPROMISED AIRWAYS?**

(If no to above, please provide a detailed explanation.)

☐ **YES** ☐ **NO 5. DID THE APPLICANT EVER RECEIVE A WARNING, REPRIMAND, OR WAS THE APPLICANT PLACED ON PROBATION DURING THE TRAINING PROGRAM?** If yes, please explain.

☐ **YES** ☐ **NO 6. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM?** If yes, please explain.

☐ **YES** ☐ **NO 7. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING CONSCIOUS SEDATION FOR PEDIATRIC OR MEDICALLY COMPROMISED PATIENTS?** If yes, please provide details.

I further certify that the above named applicant has demonstrated competency in airway management and conscious sedation.

PROGRAM DIRECTOR SIGNATURE:	**DATE:**

IOWA DENTAL BOARD
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PLEASE TYPE OR PRINT LEGIBLY IN INK.

FORM B: VERIFICATION OF CONSCIOUS SEDATION TRAINING IN A CONTINUING EDUCATION PROGRAM

SECTION 1 – APPLICANT INFORMATION

Instructions – Use this form if you obtained your training in conscious sedation from another program that must be approved by the Board (i.e. you did NOT obtain your training in conscious sedation while in a postgraduate residency program). Complete Section 1 and mail this form to the Program Director for verification of your having successfully completed this training.

NAME (First, Middle, Last, Suffix, Former/Maiden):			
MAILING ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**PHONE:**

To obtain a permit to administer conscious sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:	**DATE:**

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:			
NAME AND LOCATION OF PROGRAM:			**PHONE:**
DATES APPLICANT PARTICIPATED IN PROGRAM ►	**FROM (MO/DAY/YR):**	**TO (MO/DAY/YR):**	**DATE PROGRAM COMPLETED:**

☐ **YES** ☐ **NO 1.** **DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE TRAINING PROGRAM?**

☐ **YES** ☐ **NO 2.** **DOES THE PROGRAM COMPLY WITH PARTS 1 AND 3 OF THE 2003 AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF ANXIETY AND PAIN IN DENTISTRY?**

☐ **YES** ☐ **NO 3.** **DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?**

☐ **YES** ☐ **NO 4.** **DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE FOR PARTICIPANTS TO SUCCESSFULLY MANAGE CONSCIOUS SEDATION IN AT LEAST TWENTY (20) PATIENTS?**

AS PART OF THE CURRICULUM, ARE THE FOLLOWING CONCEPTS AND PROCEDURES TAUGHT:

☐ **YES** ☐ **NO 5.** **PHYSICAL EVALUATION;**

☐ **YES** ☐ **NO 6.** **IV SEDATION;**

☐ **YES** ☐ **NO 7.** **AIRWAY MANAGEMENT;**

☐ **YES** ☐ **NO 8.** **MONITORING; AND**

☐ **YES** ☐ **NO 9.** **BASIC LIFE SUPPORT AND EMERGENCY MANAGEMENT.**

(If no to any of above, please attach a detailed explanation.)

☐ **YES** ☐ **NO 10.** **DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING CONSCIOUS SEDATION FOR PEDIATRIC OR MEDICALLY COMPROMISED PATIENTS?** If yes, please provide details.

I further certify that the above named applicant has demonstrated competency in airway management and conscious sedation.

PROGRAM DIRECTOR SIGNATURE:	**DATE:**